**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

WADE W. WHITMER
3201 UNIVERSITY DR E, STE 115
BRYAN , TX 77802

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 54

**MFDR Tracking Number**
M4-11-4935-01

**MFDR Date Received**
AUGUST 25, 2011

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Our provider's office received incorrect claim information from the employer as to where the claims should have been mailed. Instead of providing the correct address for Texas Mutual, they gave us the physical office address. With this said, we mailed all claims to address that we were given by the employer…We finally realized after numerous attempts of sending claims and speaking with Texas Mutual, that the address was incorrect. At this point we corrected all claims and resubmitted them all with our proof of timely filing. This has been an ongoing issue that needs to be resolved."

**Amount in Dispute:** $4958.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The requestor provided emergency department treatment to the claimant on 10/06/10 and treatment of radial fracture on 10/19/10 then billed Texas mutual for this on or about 2/9/11, wrist x-ray on 10/13/10 billed on or about 3/10/11, x-ray and report on 10/27/10, wrist splint and wrist x-ray on 10/29/10 billed on or about 3/10/11 to Texas Mutual. Because the billing(s) was greater than 95 days from the date of service Texas Mutual denied payment of the bill consistent with Rule 133.20. Review of the requestor's DWC-60 packet shows no untimely exceptions provided for under the Labor Code at 0408.0272."

**Response Submitted by:** Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| October 6, 2010 to November 29, 2010 | 25605-LT, 99282-57, 73110, 73110-WP, 25609, 99080, L3908 | $4,958.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical

fee dispute.

2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 8, 2011
   - CAC-18- Duplicate claim/service
   - CAC-29-The time limit for filing has expired.
   - 224-Duplicate charge.
   - 928-HCP must submit documentation to support exception to timely filing of bill (408.0272). Notification of erroneous submission not included.

   Explanation of benefits dated August 8, 2011
   - CAC-18- Duplicate claim/service.
   - 224-Duplicate charge.

   Explanation of benefits dated August 9, 2011
   - CAC-29-The time limit for filing has expired.
   - 731-Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05
   - 928-HCP must submit documentation to support exception to timely filing of bill (408.0272). Notification of erroneous submission not included.
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**Issues**

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

**Findings**

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

**Conclusion**

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 06/14/2012<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.